# *Workshop 8: Engaging Health Care Providers*

Moderator: Carolyn K. Burr

## Engaging Providers in Perinatal HIV Prevention: The New Jersey Experience

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New Jersey's cumulative total of 41,290 AIDS cases ranks fifth in the U.S. It has the highest proportion of cases in women at 28%. Its 743 cumulative pediatric AIDS cases are the third highest total in the U.S.

In the state, 25% of HIV-infected pregnant women do not access prenatal care. More than 90% of providers offer HIV testing to pregnant women; more than 90% of the women who are offered testing accept it. Ninety-one percent of HIV-infected pregnant women know their serostatus prior to delivery (4% tested at delivery). Use of antiretroviral therapy has increased from 8.3% in 1993 to at least 67% in 1999.

Perinatal transmission of HIV has decreased from 21% in 1993 to less than 8% in 1999 (9 children infected 1999, 1 infected 2000--preliminary data). However, 40% of the mothers of the infected children had no known prenatal care. Women presenting in labor whose HIV serostatus is unknown to the provider represent a major gap in perinatal HIV prevention efforts.
However, there are options for dealing with this problem: rapid HIV tests, and several short-course therapy options.

We surveyed 12 acute-care hospitals in Essex, Hudson, and Union counties about their management of pregnant women of unknown HIV serostatus who present for delivery. Six of the nine respondents provide obstetrical care; only one had the capability for rapid HIV testing. Three (50%) of the six hospitals that provide obstetrical care always or almost always offer HIV counseling and testing services during labor; two rarely or never offer these services during labor. None had a policy for rapid HIV testing or short-course therapy. Five of the six use the standard EIA with confirmation by Western Blot; one uses the HIV DNA polymerase chain reaction (PCR) assay. The problem with these standard tests is obtaining results within 72 hours so that the infant can be treated effectively with ZDV.

To correct this situation, we decided to develop a statewide policy for management of pregnant women of unknown HIV serostatus who present for delivery. To do this our plan was to identify and involve providers and other stakeholders, educate these stakeholders as to the problem, develop a statewide policy for use by hospitals, disseminate this policy and the rationale for it, implement the policy, and evaluate its effectiveness.

We considered stakeholders those who would implement the policy or those who would have to give permission for, or encourage acceptance of, the policy. We used several sources to identify these stakeholders. To educate them concerning the issue, we ran a series of articles in AIDSline, a statewide publication on HIV and AIDS news. We also conducted roving symposia, presented at half-day statewide conferences and our Physicians 2000 meeting and published an article in *New Jersey Medicine* as well as information on our web site.

Our initial groundwork in policy development was through individualized meetings and informal discussions with major stakeholders: the obstetrical society, pediatricians, providers at Ryan White Title IV sites, MCH consortia, Medicaid providers, the state health department and the Academy of Medicine of New Jersey. This was followed by a meeting of all stakeholders at the New Jersey Department of Health and Senior Services where we presented the needs assessment; identified common concerns and goals; discussed potential strategies, including a statewide policy; and discussed potential barriers such as cost and test availability and capability.

All stakeholders were invited to provide draft policies; draft policies were combined into one policy by state health department staff and distributed. After discussion and revision of the draft, we will provide an educational program on the issue prior to the next policy discussion. This will be followed by finalization of the policy.

Obstetricians, pediatricians, and the state health department plan to collaborate to contact obstetric and pediatric hospital chairpersons about the new policy. The strategy and policy will be presented to both state chapters of the Association for Professionals in Infection Control and Epidemiology, and information will be mailed to hospital administrators, obstetrical chairpersons, pediatric chairpersons, and infection control practitioners. Other educational efforts will be launched through the Academy of Medicine of New Jersey and the AIDS Education and Training Center, as well as through collaborations with MCH consortia, ACOG, the Obstetrical Society and the Nurse Midwives association.

To implement the policy we will collaborate with the state hospital licensure staff, who may mail information to hospital administrators, obstetrics chairs, pediatric chairs, and infection control practitioners. If possible, a presentation will be made to hospital staff as part of a licensure update meeting.

There are several potential barriers to implementation of the policy:

- cost: New Jersey law already required mandatory counseling and voluntary testing of pregnant women so we are substituting one test for another
- test availability: 6 rapid tests in FDA; SUDS discontinued
- must test be done by lab?: JCAHO requirement
- volume of testing required:
  - unknown serostatus (not all 120,000 women who give birth in any year)
  - one hospital reported doing 30 per year
  - estimated 1,100-1,200 women (1% based on electronic birth certificate data) women with no prenatal care annually statewide
- considered for women who test negative early in pregnancy.

To evaluate the implementation and effectiveness of the policy we intend to: a) repeat the questionnaire survey; b) gather information from hospital surveys; and c) look at surveillance data for women presenting with unknown serostatus (number of positive rapid tests, number given short course therapy, number of children who serorevert, and number of children infected).

**Discussion Summary**

An infection control practitioner (ICP) in the audience added that before sending a letter to hospital administrators about implementing a policy for rapid testing in their hospital, you should contact the

hospital ICP because your letter will be sent to the ICP for a decision. Moreover, the ICP may be interested in rapid testing for assessment of health care workers who have had needle-stick injuries.

It is much more effective to have obstetricians (vs. pediatricians) engage or educate (or assist you in engaging or educating) obstetricians. Similar situation using pediatricians engaging or educating pediatricians.

In Connecticut, the hospitals applied a lot of pressure on the obstetricians to test the women before they came in for delivery.

One concern was how to do appropriate counseling before testing in the labor and delivery unit.

One person commented that it is remarkable to be able to get the committee together and that this may pose a potential problem.

## Using Education to Engage Providers in Reducing Perinatal HIV Transmission

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**National Pediatric & Family HIV Resource Center**

The goals of the National Pediatric & Family HIV Resource Center (NPHRC) project are to: a) increase providers' knowledge about HIV counseling and testing of pregnant women; and b) increase providers' understanding of strategies to reduce perinatal HIV transmission. The provider education model that we have chosen to employ consists of faculty training, or the "train-the trainer" model. It pairs interactive educational strategies with didactic presentations and delivers "enabling" strategies to facilitate change in provider practice.

The faculty training model: a) builds on the expertise of practicing clinicians; b) uses a standardized curriculum and training materials to minimize the burden on the faculty and to ensure quality; c) is an effective way to educate large numbers of providers; and d) leaves ongoing expertise in the community.

The goal of the training is to increase women's health care providers' knowledge of and skill in:

- HIV counseling and prevention education
- interpretation of HIV tests
- management of HIV in pregnancy
- strategies to reduce perinatal HIV transmission
- referrals to HIV experts and support services in their region.

Four areas will be targeted over 2 years. NPHRC partners with key state organizations who are asked to assist with publicity, help identify and recruit providers to be trainers, co-sponsor the faculty training, and assist in scheduling speaking engagements. A state advisory committee is established, consisting of Ryan White Care Act and CDC-funded projects, state HIV/MCH leadership, and the local or regional

AIDS Education and Training Center. Local HIV/OB/womens' health providers are identified for participation in the faculty training. These in turn will conduct educational programs for other healthcare providers, who use their new knowledge and skills in dealing with pregnant women living with HIV.

The first two areas we focused on were Mississippi and the District of Columbia. The first step was identification and involvement of stakeholders. Local needs and issues that impact on providers, the influences of geography, and HIV prevalence among women and community perceptions were analyzed in developing intervention strategies.

**Mississippi**

In Mississippi, statewide networking has brought together the Delta AIDS Education and Training Center (AETC), the Mississippi Department of Health's HIV/STD programs, the University of Mississippi Departments of OB/GYN and of Continuing Education, the March of Dimes, the HIV Rural Area Network, the Primary Care Association, the Perinatal Association, and the Mississippi Nurses Association. We have also identified the public health districts in the state most in need of this provider education.

We have discovered several major barriers to engaging providers in reducing perinatal HIV prevention. Providers themselves are reluctant to care for clients with HIV/AIDS, considering them not part of their practice. Those who are willing to provide care need support, e.g., people they can call for referrals or to get answers to their questions. The trainers themselves may lack confidence or experience as trainers. There are also barriers in the health system. Some clients lack access to care, either because they have no insurance coverage or because it is difficult to find providers within their geographical area. Urban hospitals may be experiencing financial ills and thus reducing maternal-child transmission of HIV may not be a priority.

Lessons learned thus far are to: a) involve local HIV and MCH leadership in the process; b) utilize local strengths and recognize unique constraints; c) build on existing structures and networks; and d) provide both educational and financial support for trainers.

**District of Columbia**

We considered several factors in identifying and involving our District of Columbia (D.C.) stakeholders: a) restructuring of the Department of Health under a new Health Director had created a health promotion cluster for new cross-agency and joint initiatives; b) building on existing networks; c) building on existing expertise; d) linking to existing program initiatives; e) addressing training in context of D.C. policy-making; and f) ensuring participation of historically under-served and emerging groups. This resulted in a steering committee consisting of the Department of Health's HIV/AIDS Administration and Maternal and Child Health Administration, NPHRC, the National Minority AIDS Education and Training Center (AETC), D.C. General Hospital (largest public provider for HIV-positive women, and Children's National Medical Center (CNMC) and Ryan White Title IV partners.

The first recommendation from the Steering Committee was to form a clinical advisory group for the initiative. This advisory group drew members from the local AETC, local ACOG leaders, consortia of clinics, public hospitals and a Medicaid managed care provider. This group was already engaged with clinical providers, could influence policy, had a history of involvement, could identify prospective

faculty, and represented under-served populations. They are to assist in developing standards of care and obtaining endorsements from the provider community and from health directors.

Development of the train-the-trainer program is complicated by the fact that the operational structure for the Perinatal HIV Prevention Project is also changing and evolving at this time. However, planning for the train-the-trainer program has helped consolidate some of our committees and to reinvigorate committees and workgroups that had been previously established to address perinatal HIV. Prior to this, the project did not have the resources to address or fully implement clinical provider training. To ensure input from health care providers who would be the ultimate target of the training, a sub-committee (Title IV providers) was formed to identify training needs and to review the curriculum.

Local needs or issues that impact providers of care for pregnant women are these:

- high incidence jurisdiction (in 1999 D.C. had highest AIDS case rate in the nation compared with states or other MSAs)
- HIV surveillance system is pending (but from other studies, estimated seroprevalence rate for childbearing women is 6-7 times the national average)
- although data show that the number of children infected annually has decreased recently, perceptions about the epidemic have not changed
- debate over whether to "legislate" standards of care, and
- instability in public hospitals ( in 2-year period two hospitals serving women in the neediest and most under-served communities have threatened closure).

Our next steps are to fully integrate the train-the-trainer steering committee as part of the overall Perinatal HIV Prevention Committee structure, obtain endorsements of standards of care, and increase targeted outreach to pregnant women, especially across Department of Health agencies. We will coordinate training activities with the National Minority AETC and try to be much more targeted in our efforts (if we do this one more time). We will also assess trainees who have been through the program. Finally, we will continue to link with other urban centers through the CityMatCH perinatal HIV Urban Learning Cluster.

**Discussion Summary**

Instead of establishing a DOH committee, D.C. built on existing networks in the community, including historically under-served populations. One of the barriers in engaging providers was that the Medicaid agency was reorganizing and could not participate when D.C. established the committee. Also involved were the local ACOG chapter and non-profit clinic consortia.

Mississippi added training components to existing courses for physicians, nurses, etc. Physicians get CME credits for being trainers; participants get CMEs if they apply for it well enough in advance. Having colleagues do the training should reduce the reluctance barrier. Also it's very important to use "champions" (opinion leaders).

The training symposia in both DC and Mississippi involved key HIV experts from the universities whom the future physician and nurse trainers could call. Moreover, they gave pocket-size cards to participants with the telephone numbers of the experts and a web site from which to obtain information.

The March of Dimes arranged facilities for the training in Mississippi.